## Figure 2-20-N-10 Appeals (Continued)

### 3.0 Reconsideration Background Data Form Instructions

#### I. Identifying Data--Beneficiaries/Parties

**Beneficiary Name and Address**

Provide the last known address even if the beneficiary is deceased. Indicate whether the beneficiary is living or deceased. Include the beneficiary phone number, if know.

The beneficiary information is required even if the Reconsideration is submitted by a non-plan provider or other authorized representative.

**Party Requesting Reconsideration**

One category must be checked and only one category can apply.

Check "beneficiary" unless one of the following categories applies and is indicated:

*Advocate/representative* An individual, not including valid representative of an estate or provider, who is authorized to submit a Reconsideration request on behalf of the beneficiary by virtue of execution of an appropriate form of authorization (see below).

*Estate* An authorized representative of a beneficiary's estate may request a Reconsideration.

*Provider as Representative* A non plan provider may represent a beneficiary if the case file includes an appointment of representative designating the provider.

*Provider-Appellant*-A non-plan provider, but not a provider under contract the MCO, may submit a Reconsideration on the provider's behalf if the case file includes an executed "waiver of payment" form.

**Form of Authorization**

If the beneficiary is not the party, the Plan must check and include an appropriate document authorizing another party or representative.

#### II. Identifying Data—HMO

The address and contact person entered to this section will be used by CHDR for addressing information to the MCO about this case. The MCO may use the name and address of its Key Plan Contact (see CHDR Manual). Or, the MCO may use a different individual and/or address.

If the Plan contact or address is not entered, CHDR will assume that correspondence is to be sent to the Key Plan Contact.

#### III. Background Information

**Enrollment Dates**

Enter the most recent enrollment span. If the member has prior periods of enrollment, note below the "From/To" date fields.

## Figure 2-20-N-10 Appeals (Continued)

**Member's Routine Plan Source of Care**

By "member's routine source of care" CHDR is referring to the member's "primary care physician" or "medical group" responsible for coordinating the member's care *at the time of the denial in question*. If the member was not assigned to a managing provider, or if the provider was changed during the period in question, so note in available space.

**History of Plan Use of Services**

The purpose of all questions and fields in this section is to establish whether or not a history of use of Plan services exists and, if so, whether that history indicates compliance or non-compliance with Plan rules. If Plan utilization has occurred, it is sufficient to *estimate* the number of PCP *and/or* Other encounters within the last 12 months of when the claims were processed.

*Note: it is not necessary to include detailed claims for a member's complete utilization history. Records are required only for those claims and services that are denied, and for those services that are necessary to understand the context of, or to evaluate, the denial.*

Complete the remainder of this section. Check "no" if this description applies (do not leave blank).

**IV. Case Summary**

The "Service Categories" are fields that assist CHDR to triage and manage the case and which are used for reporting. The category checked by the MCO will not influence CHDR's evaluation of the case. Check the category that most closely corresponds to the denied service in question. If there are multiple denied services in the case, check each that apply. *Be sure to circle the "denial type" and in-area indicator, for each service category checked.* "Area" refers to the formal service area of the MCO as approved by HCFA.

**V. Provider Identification Data**

The purpose of this Section is to assist CHDR to correctly identify *each* provider that is referenced in the Plan's case file. Plans should include the provider(s) of denied, or unauthorized, services, and also any providers who play a role in the case "story" (e.g., a PCP who denied services, an ambulance vendor who took the member to a non-plan ED, etc.). Plans need not identify providers whose only significance is that they are part of the member's general utilization history (i.e., history unrelated to the denied services).

Each provider is recorded in this section *only once* and, thereby, is assigned a number (one to six). If there are more than six providers, use a second sheet and re-number (7 to 12, etc.).

Use your best judgment for selecting codes for "Type" and for entering a specialty. Use of codes 1 to 3 for "Relation to Plan" will cause CHDR to consider the provider a "plan-contracting" provider for purposes of the Reconsideration.

The purpose of the Medical Records fields is to CHDR to rapidly determine if records should be found in the case file and, if not, whether the MCO has attempted to obtain charts. If issues exist regarding sufficiency or availability of medical records, these issues should be discussed in the "case narrative."

**VI. Expedited Request Processing**

The primary purpose of this section is to support HCFA monitoring of MCO compliance with regulations governing expedited determinations and reconsiderations.

## Figure 2-20-N-10 Appeals (Continued)

*Completion of the top half ("Organization Determination") is required if the party had requested an expedited organization determination for any of the denied items included in the case file. If the MCO did not grant the expedited determination, and/or if the MCO did not complete the determination within the HCFA 72 time standard, attach a brief explanation.*

Completion of the bottom half ("Plan Level Reconsideration") is required if the party had requested an expedited MCO Reconsideration for any of the denied items in the case file. *If the MCO did not grant the expedited Recon, and/or if the MCO did not complete the Recon within the HCFA time frame, attach a brief explanation.*

*Note: In cases in which the request for an expedited determination or an expedited Recon are made by phone or in person to the MCO, the MCO must include the "call log" or record of any arguments supplied by the member. Include copies of written requests.*

**VII. Denied Service/Authorization Definition**

**One complete copy of this form is required for each separate denied service or authorization contained within the Reconsideration.** For example, if an MCO denied an ambulance ride to an Emergency Department, the ED Visit, and a follow-up exam, three completed copies of this section would be required. If only one type of service is in controversy, but that service occurred over a span of time, one form can be used. Examples would include multiple inpatient admissions to the same facility, home health over a period of time, and multiple visits of the same therapy to the same provider.

Sometimes, a Plan will deny two or more related services, but the member will only appeal one of the denied services. Complete a section of this form for each separate denied service, whether or not the member has sought a reconsideration of that service (and indicate the beneficiary request in the appropriate box). For denied services which the member does not appeal, leave the "Appeal Request Date" field blank.

**Denied Service #**

Enter the number of the denied service which is being described on this copy, and the total number of denied services which will be defined (i.e., the number of completed copies of this form).

**Provider #, Denial Type, Plan Denied**

Enter the number of the provider from Section 5 that identifies the provider of the denied service (or proposed service). If a provider has not been identified, write "none".

Complete the other self explanatory fields.

**Service Date/Denial Dates**

The "service dates" (up to three spans permitted) refer to the start and end dates of services which are delivered, irrespective of the MCOs decision to cover or deny these services. The "denial dates" refer to the span of services which the Plan has denied. For a total denial, the service dates and denial dates are the same. The "denial dates" are usually not the date(s) of the MCO's "organization determination" or decision to deny care. The administrative decision date is entered under "Initial Organization Determination."

Enter the start and end dates of service to **Service Dates** (does not apply to pre-service denials). If there are multiple spans of service (e.g., multiple admissions), use more than one line. Within each span of entered Service Dates, enter the span of **Denied Dates**. For example, if a member was in a SNF from

## Figure 2-20-N-10 Appeals (Continued)

1/1/97 until 6/30/97, these would be the Service Dates. If the Plan denied the period 2/1/97 until 3/30/97 these would be the denied dates.

**Request Date, Initial Organization Determination Date, Appeal Request Date, MCO Decision Date**

These fields are required and, for expedited Reconsiderations, should be consistent with the data entered to Section VI.

**Amount in Controversy**

The "amount in controversy" is the best estimate of the amount the enrollee would have to pay, or is contesting, based upon the MCO's denial. The amount entered is for the denied service described on this particular form (not the total if two or more services are defined on two or more forms). If this amount is not precisely determined, enter an estimate. Provide an explanation if there is no basis for an estimate (e.g., denial of request for out of network care, where provider has not identified estimated charges).

Check "estimated charges" or "actual charges" if one of these fields explains the basis for the amount in controversy. Included copies of bills or proposed charges for "actual charges."

If the estimated amount in controversy has been computed in some other manner, (e.g., a balance bill above the HMO allowed amount, a copayment, etc.), explain and attach related documentation.

**Diagnosis**

This space is provided to capture the Plan's understanding of the condition being treated in the episode of care that is denied. A narrative brief description is required, coding is optional.

**Service Description**

This space is provided for a brief description of the care that was denied. Do not use it to present the rationale for the plan denial.

**4.0 Case Narrative Instructions**

**INTRODUCTION**

"Case Narrative" refers to all required components of the case file other than the *Background Data Form*. Case narrative will include text written by the MCO plus material attached to the case file. The case file must be clearly and neatly organized, with legible material and attachments. The required organization and contents are:

1. Appeal Transmittal Cover Sheet
2. Background Data Form
3. Case Narrative Section:
    - Chronology of Events
    - Plan Reason for Denial
        - Summary Statement
        - Justification
    - Member's (Provider's) Arguments for Coverage
    - Plan Rebuttal

## Figure 2-20-N-10 Appeals (Continued)

- MCO Reconsideration Process
- Attachments* (Required unless otherwise noted)
  - Subscriber Contract and Rider
  - Notice of Initial Determination (Denial)
  - Call Log/Notes of Request for Expedited Determination/Reconsideration*
  - Written Request for Reconsideration*
  - Physician Statement of Support (Call Log or written)*
  - Request and Arguments Made for Coverage and Reconsideration
  - Contested Claims and Related Medical Record
  - Relevant Plan Coverage Policies, Practice Guidelines, Technology Assessments*
  - Record of MCO Reconsideration Deliberation
  - Authorization of Legal Representatives, Waiver of Liability*

1. CHRONOLOGY OF EVENTS

General Purpose

The Chronology is the Plan's statement of the facts. It serves two basic purposes. First, it should provide a third party with a "factual" review of those events which comprise, or are necessary to understand, the dispute between the member and Plan. Second, it establishes "facts" which are referenced in the Plan's (subsequent) presentation of Plan and member arguments. "Facts" should be placed in quotes because there may be real differences in the Plan and member's views of events (e.g., whether or not a phone call was made for authorization). Such differences in "facts" must be identified in the Chronology, or in the Plan Rationale or Beneficiary Argument section of the Care Narrative.

The Chronology should not be used to present and defend the Plan's rationale for denial. Use the Plan Rationale section for this purpose.

Span of the Chronology:

Begin the chronology with the first "event" that a third party should recognize to understand the circumstances causing or starting the denial dispute. This is generally *not* the member's enrollment date, or the date of first use of Plan services. Rather, this is an event such as:

- Onset of symptoms which lead to disputed service use
- Use of a Plan provider which started a chain of referrals which lead to the disputed service
- Discussion with a provider about treatment options, or possible future referrals, related to the disputed service
- Date member left the service area, setting the stage for "out-of-area" services.

In some cases, this starting "event" may be a characterization , such as "member had been seen over a period of 5 months by his PCP for complaints related to enlargement of the prostate."

End the chronology with the member's last use, or request for, the disputed service, or the Plan's last determination. However, it is not necessary to include within the Chronology the dates and details of the Plan's reconsideration process itself, providing these are detailed in the Background Data Form.

What Events to Include in the Chronology

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* *This documentation is required as applicable to the case.*

## Figure 2-20-N-10 Appeals (Continued)

identify, and date, each event that is necessary for a third party to understand both the Plan's and member's views of the dispute. These events will usually include:

- Each *attempt* by the member to contact or access a plan or non plan provider (e.g., call for appointment)
- Each *actual contact or receipt of service* from a provider (date spans may be used when essentially the same service is offered over time, such as a facility stay or outpatient physical therapy)
- Each *attempt to contact or contact* with the Plan's administration
- Onset of symptoms or significant changes in member's health problems
- Change in member's capacity for, and control over, self care (e.g., admission to a facility) or other significant status changes (e.g., moves out of the Plan service area)

Note events (contacts or attempts to contact) in which a "significant other" to the member is acting. For example, if a child of the member had a significant discussion with a provider, this event should be acknowledged.

What to Include in the Description of Events

Include the date of the event (start and end if applicable), who was involved, a summary description and reference any attached material in the case file (e.g. "see attachment #1, medical record). You should not repeat more detailed data which is provided elsewhere. For example, you do not have to repeat Provider identifying information or (detailed) service descriptions which are also reported in the Background Data or as attachments.

Medical Service Events

For medical service events, the following information is often a necessary part of a complete description:

- How and/or why the member accessed the service
- The role, if any, played in access by Plan personnel or Plan providers (including non-plan providers acting under a Plan's one-time referral)
- The date and method by which Plan became aware of service use
- Plan and Plan provider's response to awareness of service use.

### II. PLAN RATIONALE FOR SERVICE OR AUTHORIZATION DENIAL

Purpose

The first purpose of this section of the Case Narrative is to record the Plan's reasons and arguments for its initial adverse determination (denial) and its subsequent decision to uphold this denial in Plan level Reconsideration. The "process" used by the Plan to make and uphold its denial (e.g., who made the denial, who conducted Reconsideration, etc.) will be recorded in the Reconsideration Process subsection.

Summary Statement of Reason for Denial

Provide a one or two sentence statement of the Plan's primary reason(s) for denial. Do not laundry list every conceivable reason for denial of any claim (e.g., "not covered", "not emergent" "not urgent" "not medically necessary" and "not authorized"). List only the reasons applicable to the current case, with emphasis on the most important reason. CHDR has found the following terminology for denial reasons to

## Figure 2-20-N-10 Appeals (Continued)

be useful and Plans may elect to use it. However, the Plan may state its denial rationale in any terms the Plan chooses.

*Not Enrolled* The Plan's records indicate the member was not enrolled on the date(s) which would obligate to Plan to cover the disputed service

*Not a Covered Benefit* The service or item in question is not covered under the member's contract under any normal circumstances (e.g. acupuncture). Do *not* use this terminology when referring to a service which is frequently covered, but one denied in this case because of an authorization, medical necessity or level of care issue.

*Exceeded Coverage Limits* This reason would apply if the Plan denies the service, in whole or part, because the member had exhausted a limited benefit (e.g., maximum covered days of SNF care)

*Not An Emergency* The basis for denial of *in-area* unauthorized services sought because the member perceived a medical condition to require immediate care. This reason is not applicable to out-of-area care which, by definition, need only quality as "urgent" care.

*Not Urgent* The basis for denial of out-of-area unauthorized services sought because the member perceived a medical condition to require immediate care. Do not use for in-area denials (as in, "denied--not emergent/not urgent")

*Not Unforeseen* The basis for denial when the Plan believes that "out of area" care, whether urgent or not, should have been "foreseen" by the member.

*Not Justified by Plan Delay or Withholding of Care* The basis for denial of a member's out of plan care, when the member seeks such care because of a real or perceived delay or withholding or services by the Plan.

*Not The Treatment Option (Or Provider) Approved by Plan.* Applies to a case in which the member seeks (pre service) or sought (claim denial) a form of treatment which the Plan might recognize as medically appropriate, but the Plan seeks to limit coverage to an alternative appropriate treatment (or provider).

*Not Skilled Care* The basis for denial when care is deemed custodial, or fails to meet other Medicare qualifying criteria.

*Not Authorized* Care not approved in compliance with the Plan's authorization procedures. Usually, this reason is secondary or complimentary to a reason above (e.g. "the visit to the ED was not "emergent" and was not authorized").

*Not Medically Necessary* One basis for "pre-service" denials, or withholding of Plan prior authorizations. Otherwise, usually a characterization of care which, while important, is not the primary basis for denial.

*Not Plan Provider* A characterization of a provider which is typically only a secondary reason for denial.

Justification

The contents of the Plan's justification will vary based upon its primary reason for denial.

*Denials Justified Primarily by Review of Facts*

When the denial is made due such issues as enrollment or absence of authorization, the Plan's justification will be its statement of facts and review of evidence (attached documents) which support these facts.

## Figure 2-20-N-10 Appeals (Continued)

*Denials On Issues of Coverage*

If the Plan's primary denial reason relates to an issue of coverage, the Plan should justify its denial by review and interpretation of the applicable Medicare policies, Plan subscriber contract, or both. It is helpful, but not necessary, to include a copy of the applicable Medicare policies. Reference citations to Medicare policies are required, as is attachment of the *entire* subscriber contract and riders. Do not attach only the applicable section of the subscriber contract.

*Denial On Medical Grounds*

If the Plan's denial is based upon a medical judgment (e.g. not emergency, not urgent, not skilled level, not medically necessary or not the treatment option offered by the Plan), the Plan should provide a substantive clinical justification that will meet commonly accepted standards of practice. Depending upon the circumstances within the case, elements that could be included in this justification include:

- Identification of the individual practitioners, and their licensure or certification, who made the initial denial and Plan Reconsideration uphold of this denial.
- Identification of the information upon which the denial assessment was based (e.g. exam of patient, review of medical records, discussion with provider, discussion with patient, etc.)
- Discussion of the patient's presenting symptoms or condition, diagnosis and treatment interventions and why this medical evidence falls to meet the applicable criteria (e.g., if the issue is "emergent" or "urgent" care, a discussion of the possible risks in delay of care and why these risks are deemed insignificant)
- Specification of the Plan's treatment option, when the Plan denies an alternative option requested by the member.
- Reference to and inclusion of applicable Plan practice guidelines
- Literature citations substantiating the Plan's arguments[1]

It is not CHDR's intent to suggest that Plans will be rewarded based upon the length or complexity of the justification. The intent is to require a concise presentation of the logic underlying the Plan's denial and of substantiating facts.

### III. PRESENTATION OF MEMBER'S ARGUMENTS[2] FOR COVERAGE

CHDR assumes the Plan has provided the member, (or non-plan provider if such provider is the party), with an opportunity to be heard (i.e., face-to-face input) and, if such opportunity is declined, with opportunity for provide input in writing or by phone. In this section, the Plan should summarize each argument for coverage offered by the member. This should include any differences in the member's interpretation of facts and events, if such differences have not been previously noted (i.e., in the Chronology).

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[1] Applicable only to services or procedures for which consensus regarding efficacy does not exist, such as "experimental" treatments.

[2] Non-plan provider arguments would also be presented in this section.

## Figure 2-20-N-10 Appeals (Continued)

If the Plan considered and ruled out additional arguments for coverage to those explicitly presented by the beneficiary, indicate those considerations in this section.

### IV. PLAN'S REBUTTAL TO MEMBER'S ARGUMENTS

Use this section of the narrative to explain why the member's argument is logically flawed, is not supported under Medicare policies, or is based upon an erroneous interpretation of the facts.

### V. MCO ORGANIZATION DETERMINATION AND RECONSIDERATION PROCESS

Note if there was a request for an expedited organization determination or Reconsideration. Explain the justification for withholding the expedited proceeding, or for any delays in comparison with HCFA timeliness standards.

Identify the decision makers for the MCO Reconsideration and indicate whether or not they were involved in the initial organization determination. Define how the enrollee or provider's input to the proceeding was sought and obtained.

Document the decision and justification of the Reconsideration decision maker(s). Emphasize any differences in the Plan or Member's arguments, or supporting data, that were advanced at the Reconsideration stage in comparison to the prior organization determination phase.

**Figure 2-20-N-10 Appeals (Continued)**

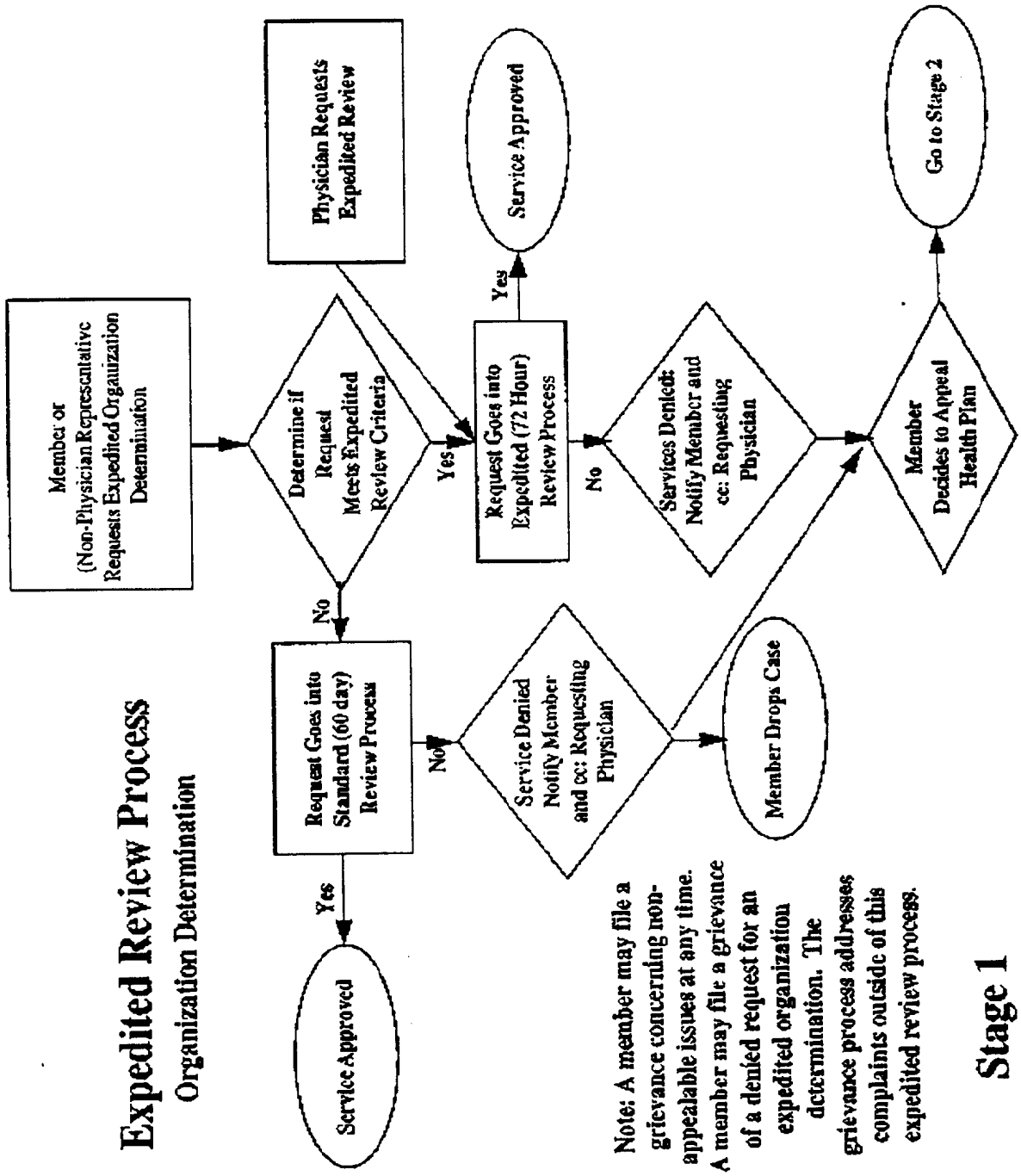
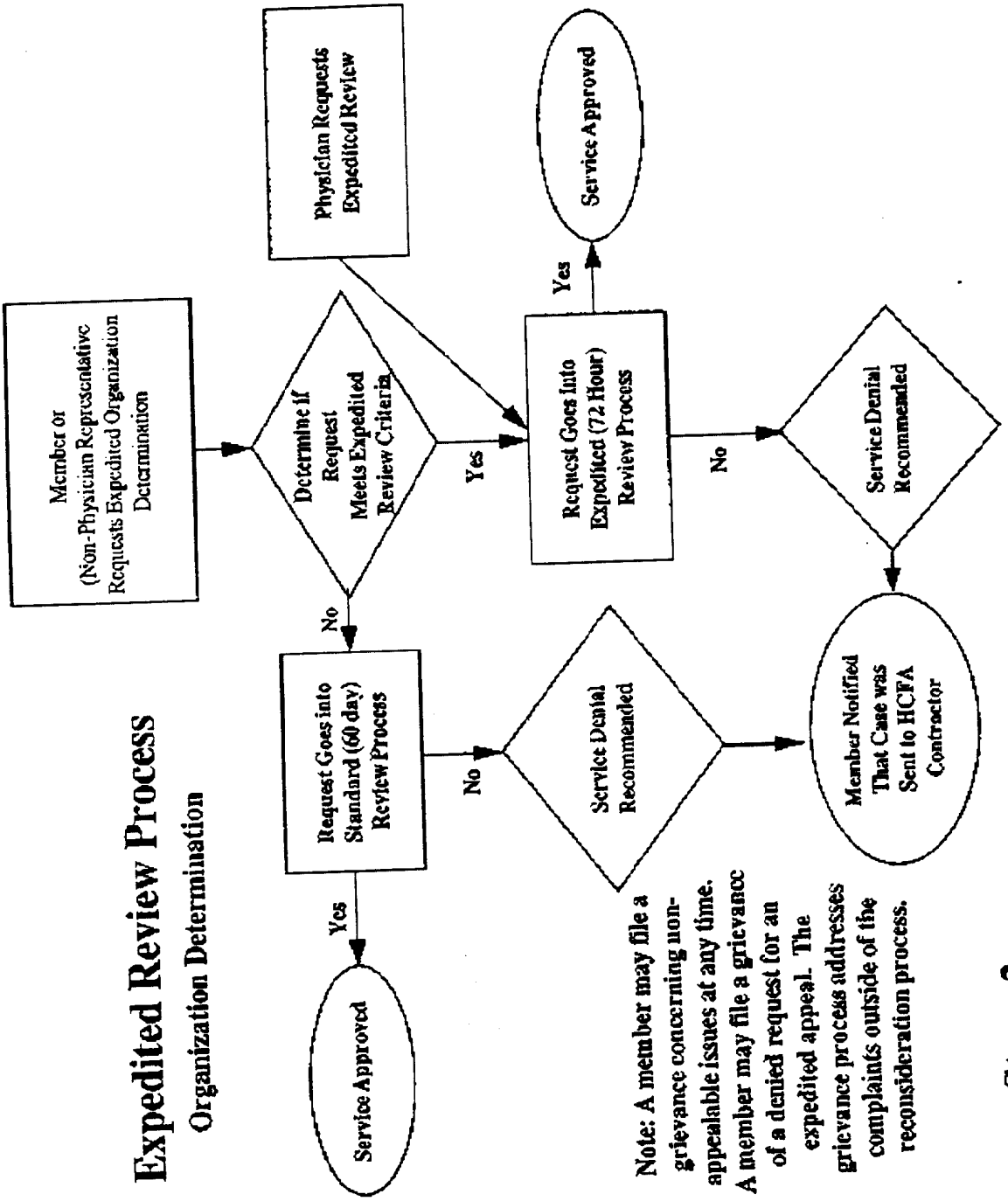


**Figure 2-20-N-10 Appeals (Continued)**



## Figure 2-20-N-10 Appeals (Continued)

**Implementation of the Expedited Appeal Regulation***

A final rule with comment, "Establishment of an Expedited Review Process for Medicare Beneficiaries Enrolled in HMOs, CMPs and HCPPs" was published on April 30 in the Federal Register. Medicare contracting health plans must be in compliance with all requirements of this final rule beginning August 28.

This Program Memorandum provides the following information:

| | | |
|---|---|---|
| 1. | Model language for Expedited Organization Determinations | (Attachment A) |
| 2. | Flow Charts: Expedited Organization Determination Process and Expedited Appeal Process | (Attachment B) |
| 3. | Comparison [illegible]ndard and Expedited Appeal Process | (Attachment C) |
| 4. | Qs and As | (Attachment D) |
| 5. | Model Appeal Language: Member Materials, Denial Notices, and Notices of Non-Coverage (NONC) | (Attachment E1) |
| 6. | Model Appeal Language for Claims Denials | (Attachment E2) |

All Medicare contracting health plans will be required to report information to the Health Care Financing Administration (HCFA) on all requests for expedited appeals. HCFA is working with the American Association of Health Plans, HMOs, and The Center for Health Dispute Resolution (The Center) to develop a standard format for collecting this information.

**Inform Medicare Enrollees of Their Right To Expedited Reviews**

You must notify all Medicare beneficiaries enrolled in your health plan of the expedited 72-hour organization determination and appeal processes and clarify that terminations of health care services are organization determinations which may be appealed. You may notify enrollees through a special letter, an article/insert in a newsletter, or other health plan publication directed to the Medicare enrollee. HCFA must approve all materials sent to Medicare enrollees.

**Use of Model Appeal Language in all Member Materials**

You must modify all member materials (member handbooks, evidence of coverage, denial notices and NONC) that describe appeal rights. Use of the attached model language will hasten approval through HCFA. There is separate Model Appeal Language for claim denial notices.

Beginning January 1, 1998, all health plan documents which describe member rights must incorporate approved language which describes the expedited organization determination process as well as the expedited appeal process. The Model Expedited Organization Determination Language is provided in Attachment A for use in member materials such as the member handbook and evidence of coverage.

## Figure 2-20-N-10 Appeals (Continued)

**Process for Expedited Review**

**Member Requests**

A Medicare enrollee or his/her representative may request, either orally or in writing, an expedited organization determination and /or expedited appeal if the enrollee or his/her representative believes the enrollee's health, life, or ability to regain maximum function may be jeopardized by the standard 60-day organization determination process and/or the standard 60-day appeal process.

you cannot require that an enrollee obtain a physician's statement of support for the expedited request. you are responsible for deciding whether the request for an expedited organization determination and/or expedited appeal meets the criteria.

**Physician Requests**

Any physician may request or provide oral or written support for an enrollee's request for an expedited organization determination and/or appeal. All physician requests (non-plan physicians as well as plan physicians) and enrollee requests with physician support must be expedited. The physician should be clear that he/she believes the situation is time sensitive and/or the review would be conducted within 72 hours or less as medically necessary or appropriate.

If a physician (whether plan or non-plan) is supporting a member's request for expedited determination or appeal, a waiver of payment or appointment of representative form is not required. Health plans may not delay the proceeding to obtain this documentation. A waiver of the provider's right to collect payment form the beneficiary remains required in a retrospective case if a non-plan provider is the appealing party. Non-plan providers do not have appeal rights on their own behalf for pre-service cases. However, a beneficiary may appoint anyone, including a non-plan provider, to be his/her representative.

**Process for Receiving Requests**

You are required to develop a meaningful process for receiving requests for expedited reviews which may include designating an office or department, phone number for oral requests, and FAX machine number to facilitate beneficiary access and health plan receipt of requests for expedited reviews (organization determinations and appeals). These procedures must b de clearly explained in member materials including denial notices and NONCs. (See the Model Appeal Language in Attachment E). In addition, health plans will be accountable for educating staff and provider networks to ensure that requests for expedited review received by medical group or other health plan offices are referred immediately to the designated health plan office or department. The 72-hour period begins when the request is received by the designated office or department.

## Figure 2-20-N-10 Appeals (Continued)

**Denied Requests**

When a request for expedited organization determination or expedited appeal is denied, you should automatically transfer it to the standard 60-day process for review (or such shorter period as required by state law or health plan policy). Do not required the enrollee to file a written appeal. The standard time frame begins with the date the request for expedited review is received. When you deny a request for expedited review, you must orally notify the enrollee immediately and follow up with a written letter of explanation within 2 working days. Include in this letter an explanation that the enrollee's request will be processed within 60-days and that if the enrollee disagrees with the decision to process the appeal in the standard 60-day time frame, the enrollee may file a grievance with the health plan. Provide instructions and the time from for the grievance process.

If an enrollee orally requests a standard 60-day appeal, instruct him/her to file a written request and indicate where it should be sent. The standard 60-day appeal process requires that appeals be requested in writing. However, as noted above, if the enrollee requests an expedited 72-hour appeal and you deny the request, you cannot require the enrollee to file a written request before you process the appeal in the standard 60-day process. You are required to document oral requests for expedited appeals in writing.

**Immediate PRO Review**

A hospital NONC must include notification of the immediate PRO review right as well as notification of the standard and expedited appeal processes. Enrollees who are inpatients at a hospital would be well advised to use the immediate PRO review process if they disagree with a decision to discharge, rather than the expedited appeal process, provided that they request the review by noon of the first working day following receipt of the NONC. Medicare law currently provides an immediate (3 working days) Pro review of hospital discharges with financial protection for the beneficiary. Thus, from a beneficiary protection perspective, the beneficiary should choose this option. If an enrollee misses the noon deadline for filing for immediate PRO review, the enrollee can still request an expedited appeal. Medicare contracting health plans should not process any request for expedited appeal when immediate PRO review is being conducted for hospital discharge. **You should revise your NONC to clearly explain these rights to enrollees.**

**Submittal of Cases to The Center**

The Center will issue revised forms and instructions for health plan submittal of HCFA-level reconsiderations (NOTE: These forms and instructions are included as part of Figure 2-20-L-12 with the Scope of Work). These revisions will address both expedited and standard reconsiderations. The new forms and instructions will be based upon, and will not substantially modify, the current instructions. The new instructions will modify case processing time frames as required by the regulations. The new forms will add those data elements necessary for monitoring health plan compliance with expedited appeal processing. One common) set of forms, based on the current forms, will be used for both types of appeals. The current

## Figure 2-20-N-10 Appeals (Continued)

requirements for the components of the case folder (e.g., medical records, plan contract language, chronologies, etc.) will remain and will apply to both expedited and standard appeals.

Health plans are expected to meet the regulation requirement to send expedited case files to The Center within 24 hours of the health plan's completion of an expedited appeal. At this time, The Center does not plan to routinely staff on weekends but will work with major delivery vendors to ensure safe and confirmed receipt of material.

Because of confidentiality and technical quality concerns, The Center is not permitted to accept case files by FAX. Hard copies of expedited cases should be sent to The Center by overnight delivery. The Center will modify the current (letter) process for acknowledgments of receipt of case files. The Center is considering a process whereby health plans would notify The Center by FAX or e-mail of the impending submission of an expedited case, with The Center confirming receipt via the same media.

### The Center's Additional Information Request Policy

For the past several years, The Center has frequently requested additional information from health plans in order to reach an informed decision.

**Effective August 28, in cases where The Center believes that additional information is necessary to reach an informed decision in a reconsideration case, The Center will request this information. Health plans should respond to The Center in accordance with the following timetable:**

| | |
|---|---|
| **Expedited Appeals** | **Within 3 days from date of request** |
| **Pre-service cases, not expedited** | **Within 10 days from the date of request** |
| **Retrospective cases** | **Within 15 days from the date of request** |

The Center reserves the right to deviate from (accelerate) these time frames for individual cases when such action is medically indicated. The Center will FAX all information requests to the health plans.

**Extensions will not be granted. Second requests for information will no longer be made by The Center. Health plans are reminded that The Center is under no statutory or regulatory requirement to request additional information from the health plans in any case. Accordingly, health plans should make every attempt to submit original case files to The Center with complete information.**

In the event that a health plan does not respond to a request for additional information, The Center will decide the case based upon the information contained in the original case file. If the health plan's documentation does not substantiate its denial of a claim, The Center will overturn the health plan's denial.

**Figure 2-20-N-10 Appeals (Continued)**

Health plans that obtain additional pertinent information after submitting a case to The Center may, on their own initiative, submit this information within 3 days of receipt of the appeal case file by The Center. The Center is under no obligation to use this information. Use of the information will depend in part on its relevance to the subject of appeal and the review stage of the case at the time of receipt of the additional information by The Center.

***This document, including the stated Attachments, is found in the HCFA Program Memorandum, Subject: Implementation of the Expedited Appeal Regulation, dated July 22, 1997**